MSSP Initial Health Assessment

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	
Staff Signature/Title			

Diagnosis/Medical History

What are the client's diagnoses?

What is the client's medical history?

What is the client's rating of his/her own health?

☐ Poor	☐ Fair	☐ Good	☐ Excellent

Has client been in a hospital, SNF or ER in past year?	☐ No	☐ Yes

If Yes, provide approximate date(s) and reason(s):

Medications

Pharmacy used:

☐ Allergies to medications	☐ Forgets medications	☐ Problem with cost
☐ Medications prescribed are covered by Medicare	☐ Has prescription medications in stock which are no longer prescribed	

☐ Primary physician knows about all of client's medications

☐ Does client have help with medications?	☐ No	☐ Yes

If yes, who helps?

What kind of help?

Medications continued

Is more help with medications needed?	☐ No	☐ Yes
If yes, describe:		
Comments S/O		

Nutritional Assessment

Y = Yes	N = No	D = Deferred

Include in your assessment:

- Usual eating
- Diet patterns
- Preparation of meals
- Shopping
- Finances
- Allergies

☐ Weight loss or gain in past year:

☐ Special diet/restricted foods:

☐ Client follows diet:

Client's appetite (subjective):

☐ Good	☐ Fair	☐ Poor	
Meals per day:	☐ 1	☐ 2	☐ 3

Assessment of client's diet quality (objective):

☐ Good	☐ Fair	☐ Poor

Nutritional Supplements?

Approximate amount/type of fluid intake:

Comments S/O

Health Habits

Y = Yes	N = No	D = Deferred
Describe usual use patterns and significant changes:		
☐ Tobacco	☐ Caffeine	☐ Alcohol
☐ HX of alcohol/drug abuse	Sleep pattern	
Comments S/O		

Review of Systems

Instructions: Check each condition identified by client or observed during the assessment. Inquire about each area as appropriate, and enter response or indicate if not a problem. It is necessary to record a response to each condition. Comments should include changes and impact of condition on function.

S=Subjective	O=Objective

Eyes/Ears/Mouth

Eyes

☐ Glasses or contact lens	☐ Trouble with vision
☐ Change in vision in last year	
Comments S/O	

Ears

☐ Trouble with hearing	☐ Wears a hearing aid
Comments S/O	

Mouth

☐ Problems with teeth/gums	☐ Dentures
☐ Problems with dentures	☐ Dentures fit well
Comments S/O	

Respiratory/Pulmonary

☐ Short of breath	☐ Uses oxygen
☐ Coughs frequently	☐ DX of tuberculosis
Comments S/O	

Cardiovascular

- ☐ Pain, tightness, or pressure in chest, neck, or arms
- ☐ Swelling of feet or ankles
- ☐ Prop pillows at night for shortness of breath
- ☐ Fainting/blackouts
- ☐ Rapid, irregular, or skipped heartbeats

☐ High blood pressure		
☐ Cramps in leg muscles	☐When walking	☐When not walking
Comments S/O		

Breasts		
☐ Lumps		
☐ Mammogram	Approximate Date	
☐ Performs breast self-exam		
Comments S/O		

Gastrointestinal		
☐ Trouble swallowing	☐ Indigestion/heartburn	☐ Nausea/vomiting
☐ Constipation	☐ Change in bowel habits	☐ Loose stools or diarrhea
☐ Blood from rectum	☐ Bowel incontinence	☐ Black or tarry stools
Comments S/O		

Genitourinary		
☐ HX Bladder disease	☐ Catheter	☐ Incontinence
☐ Frequency at night	☐ Urgency	
☐ Trouble starting/stopping urine	☐ Pain/burning with urination	
Comments S/O		

Vaginal Problems				
☐ Bleeding	☐ Discharge	☐ Odor	☐ Bulging	☐ Itching
Comments S/O				

Testicular/Prostate Problems
Comments S/O

Musculoskeletal				
☐ Back pain	☐ Falls	☐ Osteoporosis	☐ Joint pain or stiffness	
☐ Engages in physical activities		☐ Changes in activity level		☐ Foot problems
Comments S/O				

Mobility

☐ Fully ambulatory	☐ Ambulatory with assistance	☐ Cane/walker
☐ Prosthesis/appliance	☐ Occasional Wheelchair use	☐ Bed Bound

Gait (if observed):

☐ Ataxia	☐ Unsteady	☐ Poor Balance	☐ Shuffling	☐ Wide Based

Describe need for foot care:

If bed bound describe ROM:

Joint deformity description:

Comments S/O

Neurological

☐ CVA	☐ Numbness in arm, leg or face	☐ Trouble finding words/slurred speech
☐ Paralysis	☐ Headaches	☐ Dizziness
☐ Tremors	☐ Weakness	☐ Seizures

Comments S/O

Psychiatric

☐ Confused	☐ Wanders	☐ Feelings of Depression

☐ Psychiatric HX

☐ Changes in memory

Comments S/O

Endocrine

☐ Diabetes	☐ Insulin Dependent	☐ Controlled Diet
☐ Oral Hypoglycemics	☐ Thyroid Problems	

Comments S/O

Skin

☐ Rash	☐ Dry skin	☐ Itching	☐ Growths
☐ Changes in wart or mole		☐ Wounds/lesions	

☐ Sores that will not heal

Skin characteristics:

☐ Warm	☐ Cool	☐ Dry	☐ Moist	☐ Color

Comments S/O

Vital Signs		
Temperature (optional)	Respiration	
Pulse	BP (indicate position)	
Weight (history or taken)	Height (by history)	
Comments S/O		
Who provided assessment information?		
☐ Client	☐ Caregiver	☐ Family
☐ Other		
Comments S/O		
How reliable is provided information?		
Was this Assessment conducted in the client's home?		
☐ Yes	☐ No (if no, where?)	